AMENDED IN SENATE FEBRUARY 11, 2004

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CALIFORNIA LEGISLATURE—2003–04 FOURTH EXTRAORDINARY SESSION

SENATE BILL No. 9

Introduced by Senator Alarcon

November 25, 2003

An act to amend Sections ~~122, 139.2,~~ *62.5, 122, 139.2, 3201.5, 3201.7, 3201.81, 3207,* 4061, 4062, 4406, 4603.2, 4604.5, ~~4903.05, 5307.1, and 6401.7 of~~ *4658.6, 4903.05, 5307.1, 5703, and 6401.7 of, and to repeal, add, and repeal Section 139.5 of,* the Labor Code, relating to workers' compensation, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 9, as amended, Alarcon. Workers' compensation.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law establishes the Workers' Compensation Administration Revolving Fund as a special account in the State Treasury and moneys in the fund may be expended by the Department of Industrial Relations, upon appropriation by the Legislature, for the administration of the workers' compensation program. Existing law requires that 80% of the

costs of the program be borne by the General Fund and 20% of the costs of the program be borne by the employers through assessments levied by the Director of Industrial Relations.

This bill would instead require that employer assessments account for the total costs of the program, and would require the director to levy these assessments to fund the total costs of the program retroactive to January 1, 2004. It would also specify that it is the intent of the Legislature that a sufficient portion of the fund be allocated to certain priority initiatives.

Existing law requires the ~~administrative director~~ *Administrative Director of the Division of Workers' Compensation* to perform functions and duties in connection with the provision of medical services under the workers' compensation program, including appointing a medical director who has prescribed duties.

This bill would transfer the duties of the medical director to the administrative director.

Existing law, until January 1, 2004, required the administrative director to establish a vocational rehabilitation unit to perform duties in connection with vocational rehabilitation services, and provided that when an employee was determined to be medically eligible and chose to participate in a vocational rehabilitation program, he or she would continue to receive temporary disability benefits, a maintenance allowance, and additional living expenses. Chapter 639 of the Statutes of 2003, which became effective on January 1, 2004, eliminated vocational rehabilitation as part of the workers' compensation system.

This bill, until January 1, 2009, would reenact the above provisions relating to vocational rehabilitation for employees injured prior to January 1, 2004.

Existing law requires an employer to provide payment to a physician who has provided medical treatment to an injured employee as part of his or her workers' compensation benefits within 45 working days after the employer receives a billing statement and other documentation, except for employers that are governmental entities. Failure to make this payment results in that amount being increased by 15%.

This bill would further reduce this period to 45 calendar days, and would reduce the penalty from 15% to 10% of the nonpayment amount.

Existing law provides that an employee is entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury, unless an insurance carrier authorizes, in writing, these additional visits to a health care practitioner for physical medicine purposes.

This bill would instead provide that the chiropractic and physical therapy limitation does not apply when an employer authorizes, in writing, these additional visits.

Existing law authorizes the Workers' Compensation Appeals Board to receive as evidence and use as proof of any fact in dispute various reports, statements, publications, and medical treatment protocols. Existing law requires the administrative director to adopt guidelines for use in the medical treatment utilization schedule.

This bill would authorize the appeals board to receive as evidence the medical treatment guidelines adopted by the administrative director.

Existing law requires every employer to establish, implement, and maintain an effective injury prevention program. Existing law also authorizes an employer to adopt the Model Injury and Illness Prevention Program for Non-High-Hazard Employment and the Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, developed by the Division of Occupational Safety and Health. Existing law requires every workers' compensation insurer to conduct a review of these injury and illness prevention programs of each of its insureds within 4 months of the commencement of the initial insurance policy term.

This bill would instead require any workers' compensation insurer to conduct a review of these programs of each of its insureds to determine whether the insured has implemented all of the required components within 6 months of the commencement of the initial insurance policy term.

The bill would also make various clarifying changes.

This bill would declare that it would take effect immediately as an urgency statute.

Vote: $^{2}/_{3}$. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. *Section 62.5 of the Labor Code is amended to read:*

62.5. (a) *(1)* The Workers' Compensation Administration Revolving Fund is hereby created as a special account in the State Treasury. Money in the fund may be expended by the department, upon appropriation by the Legislature, for the administration of the workers' compensation program set forth in this division and

Division 4 (commencing with Section 3200), other than the activities financed pursuant to Section 3702.5, and may not be used for any other purpose.

~~(b)~~

(2) The fund shall consist of assessments made pursuant to subdivision ~~(c)~~ *(d)*. ~~Costs to the program shall be shared on a proportional basis between the General Fund and employer assessments. The General Fund appropriation shall account for 80 percent and employer~~ *Employer* assessments shall account for ~~20 percent of~~ the total costs of the program.

(3) It is the intent of the Legislature that a sufficient portion of the fund shall be allocated to the following priority initiatives:

(A) Implementation of the fraudulent claim reporting and medical fee schedule reporting provisions contained in Sections 3823 and 5307.1

(B) Implementation of a clerical upgrade to promote adequate staffing and clerical employee retention necessary to support the judicial system of the Workers' Compensation Appeals Board.

(C) The development of a cost-efficient electronic adjudication management system.

~~(c)~~

(b) (1) The Uninsured Employers Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision ~~(c)~~ *(d)*. Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the payment of nonadministrative expenses of the workers' compensation program for workers injured while employed by uninsured employers in accordance with Article 2 (commencing with Section 3710) of Chapter 4 of Part 1 of Division 4, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers injured while employed by uninsured employers. Nonadministrative expenses include audits and reports of services prepared pursuant to subdivision (b) of Section 3716.1. The assessment amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Uninsured Employers Fund shall mean the Uninsured Employers Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be advanced from the Uninsured Employers Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Uninsured Employers Benefits Trust Fund upon enactment of the annual Budget Act.

~~(d)~~

(c) (1) The Subsequent Injuries Benefits Trust Fund is hereby created as a special trust fund account in the State Treasury, of which the director is trustee, and its sources of funds are as provided in subdivision ~~(c)~~ *(d)*. Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the nonadministrative expenses of the workers' compensation program for workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments, in accordance with Article 5 (commencing with Section 4750) of Chapter 2 of Part 2 of Division 4, and Section 4 of Article XIV of the California Constitution, and shall not be used for any other purpose. All moneys collected shall be retained in the trust fund until paid as benefits to workers who have suffered serious injury and who are suffering from previous and serious permanent disabilities or physical impairments. Nonadministrative expenses include audits and reports of services pursuant to subdivision (c) of Section 4755. The assessment amount for this fund shall be stated separately.

(2) Notwithstanding any other provision of law, all references to the Subsequent Injuries Fund shall mean the Subsequent Injuries Benefits Trust Fund.

(3) Notwithstanding paragraph (1), in the event that budgetary restrictions or impasse prevent the timely payment of administrative expenses from the Workers' Compensation Administration Revolving Fund, those expenses shall be advanced from the Subsequent Injuries Benefits Trust Fund. Expense advances made pursuant to this paragraph shall be reimbursed in full to the Subsequent Injuries Benefits Trust Fund upon enactment of the annual Budget Act.

~~(e)~~

(d) (1) Separate assessments shall be levied by the director upon all employers as defined in Section 3300 for purposes of deposit in the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, and the Subsequent Injuries Benefits Trust Fund. The total amount of the assessments shall be allocated between self-insured employers and insured employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director shall adopt reasonable regulations governing the manner of collection of the assessments. The regulations shall require the assessments to be paid by self-insurers to be expressed as a percentage of indemnity paid during the most recent year for which information is available, and the assessments to be paid by insured employers to be expressed as a percentage of premium. In no event shall the assessments paid by insured employers be considered a premium for computation of a gross premium tax or agents' commission.

(2) The regulations adopted pursuant to paragraph (1) shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 2. Section 122 of the Labor Code is amended to read:

122. The administrative director shall appoint a medical director who shall possess a physician's and surgeon's certificate granted under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code. The administrative director shall employ medical assistants who shall also possess physicians' and surgeons' certificates and other staff necessary to the performance of duties relating to medical treatment and evaluation. The salaries for the medical director and his or her assistants shall be fixed by the Department of Personnel Administration, commensurate with the salaries paid by private industry to medical directors and assistant medical directors.

~~SEC. 2.~~

SEC. 3. Section 139.2 of the Labor Code is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

(b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

(2) Devotes at least one-third of total practice time to providing direct medical treatment, or has served as an agreed medical evaluator on eight or more occasions in the 12 months prior to applying to be appointed as a qualified medical evaluator.

(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:

(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.

(B) Has successfully completed a residency training program accredited by the American College of Graduate Medical Education or the osteopathic equivalent.

(C) Was an active qualified medical evaluator on June 30, 2000.

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

(4) Is a doctor of chiropractic and meets either of the following requirements:

(A) Has completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the administrative director, the Board of Chiropractic Examiners and the Council on Chiropractic Education.

(B) Has been certified in California workers' compensation evaluation by a provider recognized by the administrative director. The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).

(5) Is a psychologist and meets one of the following requirements:

(A) Is board certified in clinical psychology by a board recognized by the administrative director.

(B) Holds a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, from a university or professional school recognized by the administrative director and has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

(6) Does not have a conflict of interest as determined under the regulations adopted by the administrative director pursuant to subdivision (o).

(7) Meets any additional medical or professional standards adopted pursuant to paragraph (6) of subdivision (j).

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). In no event shall a physician whose full-time practice is limited to the forensic evaluation of disability be appointed as a qualified medical evaluator under this subdivision.

(d) The qualified medical evaluator, upon request, shall be reappointed if he or she meets the qualifications of subdivision (b) and meets all of the following criteria:

(1) Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director.

(2) Has not had more than five of his or her evaluations that were considered by a workers' compensation administrative law judge at a contested hearing rejected by the workers' compensation administrative law judge or the appeals board pursuant to this section during the most recent two-year period during which the physician served as a qualified medical evaluator. If the workers' compensation administrative law judge or the appeals board rejects the qualified medical evaluator's report on the basis that it fails to meet the minimum standards for those reports established by the administrative director or the appeals board, the workers' compensation administrative law judge or the appeals board, as the case may be, shall make a specific finding to that effect, and shall give notice to the medical evaluator and to the administrative director. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

(3) Has completed within the previous 24 months at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the administrative director.

(4) Has not been terminated, suspended, placed on probation, or otherwise disciplined by the administrative director during his or her most recent term as a qualified medical evaluator.

If the evaluator does not meet any one of these criteria, the administrative director may in his or her discretion reappoint or deny reappointment according to regulations adopted by the administrative director. In no event may a physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license has been revoked or terminated by the licensing authority be reappointed.

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under

subdivision (k) or (*l*) whenever either of the following conditions occurs:

(1) The evaluator's license to practice in California has been suspended by the relevant licensing authority so as to preclude practice, or has been revoked or terminated by the licensing authority.

(2) The evaluator has failed to timely pay the fee required by the administrative director pursuant to subdivision (n).

(f) The administrative director shall furnish a physician, upon request, with a written statement of its reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the administrative director shall review his or her decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of its final decision within 60 days after receipt of the physician's response.

(g) The administrative director shall establish agreements with qualified medical evaluators to assure the expeditious evaluation of cases assigned to them for comprehensive medical evaluations.

(h) (1) When the injured worker is not represented by an attorney, the administrative director shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice. The administrative director shall use a random selection method for assigning panels of qualified medical evaluators. The administrative director shall select evaluators who are specialists of the type selected by the employee. The administrative director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state

in a clear and conspicuous location and type: ''You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will consider the evaluation prepared by the doctor you select to decide your claim.''

(3) When compiling the list of evaluators from which to select randomly, the administrative director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the administrative director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the administrative director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The administrative director shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The administrative director shall prepare an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical

evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The administrative director shall develop regulations governing the provision of extensions of the 30-day period in cases: (A) where the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline; and, (B) to extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. For purposes of this subdivision, ''good cause'' means: (i) medical emergencies of the evaluator or evaluator's family; (ii) death in the evaluator's family; or, (iii) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business. The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury. In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that an evaluation of anatomical loss, functional loss, and the presence of physical complaints be supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community.

(3) Procedures governing the determination of any disputed medical issues.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.

(C) Any other evaluation procedure requested by the administrative director deemed appropriate.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

(k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (*l*), determines, based on substantial evidence, that a qualified medical evaluator:

(1) Has violated any material statutory or administrative duty.

(2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

(3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).

(4) Has failed to meet the requirements of subdivision (b) or (c).

(5) Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.

(6) Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

No hearing shall be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:

(A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

(*l*) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

(m) The administrative director shall terminate from the list of medical evaluators any physician where licensure has been terminated by the relevant licensing board, or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude. The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board. If a physician is suspended or terminated as a qualified medical evaluator under this subdivision, a report prepared by the physician that is not complete, signed, and furnished to one or more of the parties prior to the date of conviction or action of the licensing board, whichever is earlier, shall not be admissible in any proceeding

before the appeals board nor shall there be any liability for payment for the report and any expense incurred by the physician in connection with the report.

(n) Each qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature and shall not be used by any other department or agency or for any purpose other than administration of the programs of the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

(o) An evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision.

~~SEC. 3.~~

SEC. 4. Section 139.5 of the Labor Code is repealed.

~~139.5. (a) Except as provided in Section 4658.6, if the injury causes permanent partial disability and the injured employee does not return to work for the employer within 60 days of the termination of temporary disability, the injured employee shall be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools, as follows:~~

~~(1) Up to four thousand dollars ($4,000) for permanent partial disability awards of less than 15 percent.~~

~~(2) Up to six thousand dollars ($6,000) for permanent partial disability awards between 15 and 25 percent.~~

~~(3) Up to eight thousand dollars ($8,000) for permanent partial disability awards between 26 and 49 percent.~~

~~(4) Up to ten thousand dollars ($10,000) for permanent partial disability awards between 50 and 99 percent.~~

~~(b) The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or~~

~~skill enhancement. No more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. The administrative director shall adopt regulations governing the form of payment, direct reimbursement to the injured employee upon presentation to the employer of appropriate documentation and receipts, and any other matters necessary to the proper administration of the supplemental job displacement benefit.~~

~~(c) Within 10 days of the last payment of temporary disability the employer shall provide to the employee in the form and manner prescribed by the administrative director information that provides notice of rights under this section. This notice shall be sent by certified mail.~~

~~(d) This section shall apply to injuries occurring on or after January 1, 2004.~~

SEC. 5. Section 139.5 is added to the Labor Code, to read:

139.5. (a) The administrative director shall establish a vocational rehabilitation unit, which shall include appropriate professional staff, and which shall have the following duties:

(1) To foster, review, and approve vocational rehabilitation plans developed by a qualified rehabilitation representative of the employer, insurer, state agency, or employee. Plans agreed to by the employer and employee do not require approval by the vocational rehabilitation unit unless the employee is unrepresented.

(2) To develop rules and regulations, to be promulgated by the administrative director, providing for a procedure in which an employee may waive the services of a qualified rehabilitation representative where the employee has been enrolled and made substantial progress toward completion of a degree or certificate from a community college, California State University, or the University of California and desires a plan to complete the degree or certificate. These rules and regulations shall provide that this waiver as well as any plan developed without the assistance of a qualified rehabilitation representative must be approved by the rehabilitation unit.

(3) To develop rules and regulations, to be promulgated by the administrative director, which would expedite and facilitate the identification, notification, and referral of industrially injured employees to vocational rehabilitation services.

(4) To coordinate and enforce the implementation of vocational rehabilitation plans.

(5) To develop a fee schedule, to be promulgated by the administrative director, governing reasonable fees for vocational rehabilitation services provided on and after January 1, 1991. The initial fee schedule promulgated under this paragraph shall be designed to reduce the cost of vocational rehabilitation services by 10 percent from the level of fees paid during 1989. On or before July 1, 1994, the administrative director shall establish the maximum aggregate permissible fees that may be charged for counseling. Those fees shall not exceed four thousand five hundred dollars ($4,500) and shall be included within the sixteen thousand dollar ($16,000) cap. The fee schedule shall permit up to (A) three thousand dollars ($3,000) for vocational evaluation, evaluation of vocational feasibility, initial interview, vocational testing, counseling and research for plan development, and preparation of the Division of Workers' Compensation Form 102, and (E) three thousand five hundred dollars ($3,500) for plan monitoring, job seeking skills, and job placement research and counseling. However, in no event shall the aggregate of (A) and (B) exceed four thousand five hundred dollars ($4,500).

(6) To develop standards, to be promulgated by the administrative director, for governing the timeliness and the quality of vocational rehabilitation services.

(b) The salaries of the personnel of the vocational rehabilitation unit shall be fixed by the Department of Personnel Administration.

(c) When an employee is determined to be medically eligible and chooses to participate in a vocational rehabilitation program, he or she shall continue to receive temporary disability indemnity payments only until his or her medical condition becomes permanent and stationary and, thereafter, may receive a maintenance allowance. Rehabilitation maintenance allowance payments shall begin after the employee's medical condition becomes permanent and stationary, upon a request for vocational rehabilitation services. Thereafter, the maintenance allowance shall be paid for a period not to exceed 52 weeks in the aggregate, except where the overall cap on vocational rehabilitation services can be exceeded under this section or Section 4642 or subdivision (d) or (e) of Section 4644.

The employee also shall receive additional living expenses necessitated by the vocational rehabilitation services, together with all reasonable and necessary vocational training, at the expense of the employer, but in no event shall the expenses, counseling fees, training, maintenance allowance, and costs associated with, or arising out of, vocational rehabilitation services incurred after the employee's request for vocational rehabilitation services, except temporary disability payments, exceed sixteen thousand dollars ($16,000). The administrative director shall adopt regulations to ensure that the continued receipt of vocational rehabilitation maintenance allowance benefits is dependent upon the injured worker's regular and consistent attendance at, and participation in, his or her vocational rehabilitation program.

(d) The amount of the maintenance allowance due under subdivision (c) shall be two-thirds of the employee's average weekly earnings at the date of injury payable as follows:

(1) The amount the employee would have received as continuing temporary disability indemnity, but not more than two hundred forty-six dollars ($246) a week for injuries occurring on or after January 1, 1990.

(2) At the employee's option, an additional amount from permanent disability indemnity due or payable, sufficient to provide the employee with a maintenance allowance equal to two-thirds of the employee's average weekly earnings at the date of injury subject to the limits specified in subdivision (a) of Section 4453 and the requirements of Section 4661.5. In no event shall temporary disability indemnity and maintenance allowance be payable concurrently.

If the employer disputes the treating physician's determination of medical eligibility, the employee shall continue to receive that portion of the maintenance allowance payable under paragraph (1) pending final determination of the dispute. If the employee disputes the treating physician's determination of medical eligibility and prevails, the employee shall be entitled to that portion of the maintenance allowance payable under paragraph (1) retroactive to the date of the employee's request for vocational rehabilitation services. These payments shall not be counted against the maximum expenditures for vocational rehabilitation services provided by this section.

(e) No provision of this section nor of any rule, regulation, or vocational rehabilitation plan developed or promulgated under this section nor any benefit provided pursuant to this section shall apply to an injured employee whose injury occurred prior to January 1, 1975. Nothing in this section shall affect any plan, benefit, or program authorized by this section as added by Chapter 1513 of the Statutes of 1965 or as amended by Chapter 83 of the Statutes of 1972.

(f) The time within which an employee may request vocational rehabilitation services is set forth in Sections 5405.5, 5410, and 5803.

(g) An offer of a job within state service to a state employee in State Bargaining Unit 1, 4, 15, 18, or 20 at the same or similar salary and the same or similar geographic location is a prima facie offer of vocational rehabilitation under this statute.

(h) It shall be unlawful for a qualified rehabilitation representative or rehabilitation counselor to refer any employee to any work evaluation facility or to any education or training program if the qualified rehabilitation representative or rehabilitation counselor, or a spouse, employer, coemployee, or any party with whom he or she has entered into contract, express or implied, has any proprietary interest in or contractual relationship with the work evaluation facility or education or training program. It shall also be unlawful for any insurer to refer any injured worker to any rehabilitation provider or facility if the insurer has a proprietary interest in the rehabilitation provider or facility or for any insurer to charge against any claim for the expenses of employees of the insurer to provide vocational rehabilitation services unless those expenses are disclosed to the insured and agreed to in advance.

(i) Any charges by an insurer for the activities of an employee who supervises outside vocational rehabilitation services shall not exceed the vocational rehabilitation fee schedule, and shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section. These charges shall be attributed as expenses by the insurer and not losses for purposes of insurance rating pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Division 2 of the Insurance Code.

(j) Any costs of an employer of supervising vocational rehabilitation services shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section.

(k) This section shall apply only to injuries occurring before January 1, 2004.

(l) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

SEC. 6. Section 3201.5 of the Labor Code is amended to read:

3201.5. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction inspection and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division *or a supplemental job displacement benefit program*.

(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.

(3) Employers or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(4) Employers covered by an owner or general contractor provided wrap-up insurance policy applicable to a single

construction site that develops workers' compensation insurance premiums of two million dollars ($2,000,000) or more with respect to those employees covered by that wrap-up insurance policy.

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a) of Section 3201.5.

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(h) Commencing July 1, 1995, and annually thereafter, the Division of Workers' Compensation shall report to the Director of the Department of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) The number of workers participating in vocational rehabilitation.

(9) The number of workers participating in light-duty programs.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of

employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 7. Section 3201.7 of the Labor Code is amended to read:

3201.7. (a) Except as provided in subdivision (b), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any labor-management agreement that meets all of the following requirements:

(1) The labor-management agreement has been negotiated separate and apart from any collective bargaining agreement covering affected employees.

(2) The labor-management agreement is restricted to the establishment of the terms and conditions necessary to implement this section.

(3) The labor-management agreement has been negotiated in accordance with the authorization of the administrative director pursuant to subdivision (d), between an employer or groups of employers and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(A) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(B) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(C) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(D) Joint labor management safety committees.

(E) A light-duty, modified job, or return-to-work program.

(F) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division *or a supplemental job displacement benefit program*.

(b) Nothing in this section shall allow a labor-management agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages during the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000) or more, and employing at least 50 employees, or any employer that paid an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000), and employing at least 50 employees in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of five hundred thousand dollars ($500,000) or more.

(3) Employers or groups of employers, including cities and counties, that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(d) Any recognized or certified exclusive bargaining representative in an industry not covered by Section 3201.5, may file a petition with the administrative director seeking permission to negotiate with an employer or group of employers to enter into a labor-management agreement pursuant to this section. The petition shall specify the bargaining unit or units to be included, the names of the employers or groups of employers, and shall be accompanied by proof of the labor union's status as the exclusive bargaining representative. The current collective bargaining agreement or agreements shall be attached to the petition. The petition shall be in the form designated by the administrative director. Upon receipt of the petition, the administrative director shall promptly verify the petitioner's status as the exclusive bargaining representative. If the petition satisfies the requirements set forth in this subdivision, the administrative director shall issue a letter advising each employer and labor representative of their eligibility to enter into negotiations, for a period not to exceed one year, for the purpose of reaching agreement on a labor-management agreement pursuant to this section. The parties may jointly request, and shall be granted, by the administrative director, an additional one-year period to negotiate an agreement.

(e) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the labor-management agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the labor-management agreement.

(3) The name, address, and telephone number of the contact person of the employer.

(4) Any other information that the administrative director deems necessary to further the purposes of this section.

(f) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, where such filing is required by law, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(g) Commencing July 1, 2005, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of labor-management agreements received and the number of employees covered by these agreements.

(h) By June 30, 2006, and annually thereafter, the administrative director shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) The number of workers participating in vocational rehabilitation.

(9) The number of workers participating in light-duty programs.

(10) Overall worker satisfaction.

The division shall have the authority to require employers and groups of employers participating in labor-management agreements pursuant to this section to provide the data listed above.

(i) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (f) and (g) based on the labor-management agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the administrative director shall make available an updated list of employers and unions entering into labor-management agreements authorized by this section.

SEC. 8. Section 3201.81 of the Labor Code is amended to read:

3201.81. In the horse racing industry, the organization certified by the California Horse Racing Board to represent the majority of licensed jockeys pursuant to subdivision (b) of Section 19612.9 of the Business and Professions Code is the labor organization authorized to negotiate the collective bargaining agreement establishing an alternative dispute resolution system for licensed jockeys pursuant to Section ~~3201.8~~ *3201.7*.

SEC. 9. Section 3207 of the Labor Code is amended to read:

3207. ''Compensation'' means compensation under Division 4 and includes every benefit or payment conferred by Division 4 upon an injured employee, including vocational rehabilitation *or, supplemental job displacement benefit* or in the event of his *or her* death, upon his *or her* dependents, without regard to negligence.

SEC. 10. Section 4061 of the Labor Code is amended to read:

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of a panel of qualified medical

evaluators, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

(b) Each notice required by subdivision (a) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:

''Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.''

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical

evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.

(d) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional medical evaluation. The employer shall immediately provide the employee with a form prescribed by the administrative director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.

For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.

(e) If an employee obtains a qualified medical evaluator from a panel pursuant to subdivision (d) or pursuant to subdivision (b) of Section 4062, and thereafter becomes represented by an attorney and obtains an additional qualified medical evaluator, the employer shall have a corresponding right to secure an additional qualified medical evaluator.

(f) The represented employee shall be responsible for making an appointment with an agreed medical evaluator.

(g) The unrepresented employee shall be responsible for making an appointment with a qualified medical evaluator

selected from a panel of three qualified medical evaluators. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, ''good cause'' shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive medical evaluation according to the procedures promulgated by the administrative director under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the medical findings on a form prescribed by the administrative director. The comprehensive medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(i) Except as provided in Section 139.3, the medical evaluator may obtain consultations from other physicians who have treated the employee for the injury whose expertise is necessary to provide a complete and accurate evaluation.

(j) The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the

employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(k) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 or 4750 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(*l*) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(m) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the

employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute. If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

(n) No issue relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations or need for continuing medical care resulting from the injury shall be obtained prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.

~~SEC. 4.~~

SEC. 11. Section 4062 of the Labor Code is amended to read:

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning

the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical

recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.

(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

(d) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. Except in cases where the treating physician's recommendation that spinal surgery be performed pursuant to subdivision (b), the

employer shall immediately provide the employee with a form prescribed by the administrative director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

(e) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (d) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(f) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

(g) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

(h) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.

~~SEC. 5.~~

SEC. 12. Section 4406 of the Labor Code is amended to read:

4406. (a) Payments as advances on workers' compensation asbestos workers' benefits shall be furnished an asbestos worker for injury resulting in asbestosis, or the dependents of the asbestos worker in the case of his or her death due to asbestosis, subject to the provisions of this division, if all of the following conditions occur:

(1) The asbestos worker demonstrates to the account that at the time of exposure, the asbestos worker was performing services and was acting within the scope of his or her duties in an occupation that subjected the asbestos worker to the exposure to asbestos.

(2) The asbestos worker demonstrates to the account that he or she is suffering from asbestosis.

(3) The asbestos worker demonstrates to the account that he or she developed asbestosis from the employment.

(4) The asbestos worker is entitled to compensation for asbestosis as otherwise provided for in this division.

(b) The findings of the account with regard to the conditions in subdivision (a) shall not be evidence in any other proceeding.

(c) The account shall require the asbestos worker to submit to an independent medical examination unless the information and assistance officer, in consultation with the administrative director or his or her designee, determines that there exists adequate medical evidence that the worker developed asbestosis from the employment.

~~SEC. 6.~~

SEC. 13. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(b) (1) Except as provided in subdivision (d) of Section 4603.4, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 45 calendar days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the 45-calendar-day period shall be increased by 10 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

(A) Pays the uncontested amount within the 45-calendar-day period.

(B) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill which includes charges from a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the bill shall satisfy the requirements of this paragraph.

If an employer contests all or part of a billing, any amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid. If any contested amount is determined payable by the appeals board, the defendant shall be ordered to reimburse the provider for any filing fees paid pursuant to Section 4903.05.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(2) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or authorized by the treating physician selected by the employee or

designated by the employer shall be made within 60 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(3) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

~~SEC. 7.~~

SEC. 14. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices as generally accepted by the health care community, and shall apply the current standards of care, including, but not limited to, appropriate and inappropriate diagnostic techniques, treatment modalities, adjustive modalities, length of treatment, and appropriate specialty referrals. These guidelines shall be educational and designed to assist providers by offering an analytical framework for the evaluation and treatment of the more common problems of injured workers, and shall assure appropriate and necessary care for all injured workers diagnosed with industrial conditions.

(c) Three months after the publication date of the updated American College of Occupational and Environmental ~~Medicine~~ *Medicine's* Occupational Medical Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental *Medicine's Occupational* Medical Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.

(d) Notwithstanding the medical treatment utilization schedule ~~or the guidelines set forth in the American College of Occupational and Environmental Medical Practice Guidelines, for injuries~~ *, for injuries* occurring on and after January 1, 2004, an employee shall be entitled to ~~no~~ *chiropractic and physical therapy visits as set forth in the American College of Occupational and Environmental Medicine's Medical Practice Guidelines, but in no case* more than

24 chiropractic and 24 physical therapy visits per industrial injury. This subdivision shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for chiropractic or physical therapy services, or both.

(e) The presumption afforded to the treating physician in Section 4062.9 shall not be applicable to cases arising under this section.

(f) For all ~~injuries~~ *medical treatments* not covered by the American College of Occupational and Environmental ~~Medicine~~ *Medicine's* Occupational ~~Medicine~~ *Medical* Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the medical community.

~~SEC. 8.~~

SEC. 15. Section 4658.6 of the Labor Code is amended to read:

4658.6. The employer shall not be liable for the supplemental job displacement benefit if the employer meets either of the following conditions:

(a) *Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, return to work in the same job in which the employee was employed at the time of the injury, lasting at least 12 months.*

(b) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, modified work, ~~accommodating the employee's work restrictions, lasting at least 12 months~~ *meeting all of the following conditions:*

(1) The employee has the ability to perform the essential functions of the job provided.

(2) The job provided is in a regular position lasting at least 12 months.

(3) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(4) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

~~(b)~~

(c) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee rejects, or fails to accept, in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:

(1) The employee has the ability to perform the essential functions of the job provided.

(2) The job provided is in a regular position lasting at least 12 months.

(3) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(4) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

SEC. 16. Section 4903.05 of the Labor Code is amended to read:

4903.05. (a) A filing fee of one hundred dollars ($100) shall be charged for each initial lien filed by providers*, or on behalf of providers*, pursuant to subdivision (b) of Section 4903.

(b) No filing fee shall be required for liens filed by the Veterans Administration, the Medi-Cal program, or public hospitals.

(c) The filing fee shall be collected by the court administrator. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund. Any fees collected from providers shall be used to offset the amount of fees assessed on employers under Section 62.5.

(d) The court administrator shall adopt reasonable rules and regulations governing the procedures for the collection of the filing fee.

~~SEC. 9.~~

SEC. 17. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services, other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician

services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j) and physician services provided in subdivisions (k) and (*l*), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) The maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded

hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) ''Medicare Economic Index'' means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) ''Hospital market basket'' means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) ''Hospital market basket for excluded hospitals'' means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director further reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

~~SEC. 10.~~

SEC. 18. Section 5703 of the Labor Code is amended to read:

5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:

(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized, as required by regulations adopted by the appeals board. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.

(i) The medical treatment guidelines in effect pursuant to Section 4604.5.

SEC. 19. Section 6401.7 of the Labor Code is amended to read:

6401.7. (a) Every employer shall establish, implement, and maintain an effective injury prevention program. The program shall be written, except as provided in subdivision (e), and shall include, but not be limited to, the following elements:

(1) Identification of the person or persons responsible for implementing the program.

(2) The employer's system for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices.

(3) The employer's methods and procedures for correcting unsafe or unhealthy conditions and work practices in a timely manner.

(4) An occupational health and safety training program designed to instruct employees in general safe and healthy work practices and to provide specific instruction with respect to hazards specific to each employee's job assignment.

(5) The employer's system for communicating with employees on occupational health and safety matters, including provisions designed to encourage employees to inform the employer of hazards at the worksite without fear of reprisal.

(6) The employer's system for ensuring that employees comply with safe and healthy work practices, which may include disciplinary action.

(b) The employer shall correct unsafe and unhealthy conditions and work practices in a timely manner based on the severity of the hazard.

(c) The employer shall train all employees when the training program is first established, all new employees, and all employees given a new job assignment, and shall train employees whenever new substances, processes, procedures, or equipment are introduced to the workplace and represent a new hazard, and whenever the employer receives notification of a new or previously unrecognized hazard. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use employee training provided to the employer's employees under a construction industry occupational safety and health training program approved by the division to comply with the requirements of subdivision (a) relating to employee training, and shall only be required to provide training on hazards specific to an employee's job duties.

(d) The employer shall keep appropriate records of steps taken to implement and maintain the program. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use records relating to employee training provided to the employer in connection with an occupational safety and health training

program approved by the division to comply with the requirements of this subdivision, and shall only be required to keep records of those steps taken to implement and maintain the program with respect to hazards specific to an employee's job duties.

(e) (1) The standards board shall adopt a standard setting forth the employer's duties under this section, on or before January 1, 1991, consistent with the requirements specified in subdivisions (a), (b), (c), and (d). The standards board, in adopting the standard, shall include substantial compliance criteria for use in evaluating an employer's injury prevention program. The board may adopt less stringent criteria for employers with few employees and for employers in industries with insignificant occupational safety or health hazards.

(2) Notwithstanding subdivision (a), for employers with fewer than 20 employees who are in industries that are not on a designated list of high hazard industries and who have a workers' compensation experience modification rate of 1.1 or less, and for any employers with fewer than 20 employees who are in industries that are on a designated list of low hazard industries, the board shall adopt a standard setting forth the employer's duties under this section consistent with the requirements specified in subdivisions (a), (b), and (c), except that the standard shall only require written documentation to the extent of documenting the person or persons responsible for implementing the program pursuant to paragraph (1) of subdivision (a), keeping a record of periodic inspections pursuant to paragraph (2) of subdivision (a), and keeping a record of employee training pursuant to paragraph (4) of subdivision (a). To any extent beyond the specifications of this subdivision, the standard shall not require the employer to keep the records specified in subdivision (d).

(3) The division shall establish a list of high hazard industries using the methods prescribed in Section 6314.1 for identifying and targeting employers in high hazard industries. For purposes of this subdivision, the ''designated list of high hazard industries'' shall be the list established pursuant to this paragraph.

For the purpose of implementing this subdivision, the Department of Industrial Relations shall periodically review, and as necessary revise, the list.

(4) For the purpose of implementing this subdivision, the Department of Industrial Relations shall also establish a list of low

hazard industries, and shall periodically review, and as necessary revise, that list.

(f) The standard adopted pursuant to subdivision (e) shall specifically permit employer and employee occupational safety and health committees to be included in the employer's injury prevention program. The board shall establish criteria for use in evaluating employer and employee occupational safety and health committees. The criteria shall include minimum duties, including the following:

(1) Review of the employer's (A) periodic, scheduled worksite inspections, (B) investigation of causes of incidents resulting in injury, illness, or exposure to hazardous substances, and (C) investigation of any alleged hazardous condition brought to the attention of any committee member. When determined necessary by the committee, the committee may conduct its own inspections and investigations.

(2) Upon request from the division, verification of abatement action taken by the employer as specified in division citations.

If an employer's occupational safety and health committee meets the criteria established by the board, it shall be presumed to be in substantial compliance with paragraph (5) of subdivision (a).

(g) The division shall adopt regulations specifying the procedures for selecting employee representatives for employer-employee occupational health and safety committees when these procedures are not specified in an applicable collective bargaining agreement. No employee or employee organization shall be held liable for any act or omission in connection with a health and safety committee.

(h) The employer's injury prevention program, as required by this section, shall cover all of the employer's employees and all other workers who the employer controls or directs and directly supervises on the job to the extent these workers are exposed to worksite and job assignment specific hazards. Nothing in this subdivision shall affect the obligations of a contractor or other employer which controls or directs and directly supervises its own employees on the job.

(i) Where a contractor supplies its employee to a state agency employer on a temporary basis, the state agency employer may assess a fee upon the contractor to reimburse the state agency for

the additional costs, if any, of including the contract employee within the state agency's injury prevention program.

(j) (1) The division shall prepare a Model Injury and Illness Prevention Program for Non-High-Hazard Employment, and shall make copies of the model program prepared pursuant to this subdivision available to employers, upon request, for posting in the workplace. An employer who adopts and implements the model program prepared by the division pursuant to this paragraph in good faith shall not be assessed a civil penalty for the first citation for a violation of this section issued after the employer's adoption and implementation of the model program.

(2) For purposes of this subdivision, the division shall establish a list of non-high-hazard industries in ~~California, that may include the industries that, pursuant to Section 14316 of Title 8 of the California Code of Regulations, are not currently required to keep records of occupational injuries and illnesses under Article 2 (commencing with Section 14301) of Subchapter 1 of Chapter 7 of Division 1 of Title 8 of the California Code of Regulations.~~ *California*. These industries, identified by their Standard Industrial Classification Codes, as published by the United States Office of Management and Budget in the Manual of Standard Industrial Classification Codes, 1987 Edition, are apparel and accessory stores (Code 56), eating and drinking places (Code 58), miscellaneous retail (Code 59), finance, insurance, and real estate (Codes 60–67), personal services (Code 72), business services (Code 73), motion pictures (Code 78) except motion picture production and allied services (Code 781), legal services (Code 81), educational services (Code 82), social services (Code 83), museums, art galleries, and botanical and zoological gardens (Code 84), membership organizations (Code 86), engineering, accounting, research, management, and related services (Code 87), private households (Code 88), and miscellaneous services (Code 89). To further identify industries that may be included on the list, the division shall also consider data from a rating organization, as defined in Section 11750.1 of the Insurance Code, the Division of Labor Statistics and Research~~, including the logs of occupational injuries and illnesses maintained by employers on Form CAL/OSHA No. 200, or its equivalent, as required by Section 14301 of Title 8 of the California Code of Regulations, and~~, *and* all other appropriate information. The list shall be

established by June 30, 1994, and shall be reviewed, and as necessary revised, biennially.

(3) The division shall prepare a Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, and shall determine which industries have historically utilized seasonal or intermittent employees. An employer in an industry determined by the division to have historically utilized seasonal or intermittent employees shall be deemed to have complied with the requirements of subdivision (a) with respect to a written injury prevention program if the employer adopts the model program prepared by the division pursuant to this paragraph and complies with any instructions relating thereto.

(k) With respect to any county, city, city and county, or district, or any public or quasi-public corporation or public agency therein, including any public entity, other than a state agency, that is a member of, or created by, a joint powers agreement, subdivision (d) shall not apply.

(*l*) Every workers' compensation insurer shall conduct a review, including a written report as specified below, of the injury and illness prevention program (IIPP) of each of its insureds with an experience modification of 2.0 or greater within six months of the commencement of the initial insurance policy term. The review shall determine whether the insured has implemented all of the required components of the IIPP, and evaluate their effectiveness. The training component of the IIPP shall be evaluated to determine whether training is provided to line employees, supervisors, and upper level management, and effectively imparts the information and skills each of these groups needs to ensure that all of the insured's specific health and safety issues are fully addressed by the insured. The reviewer shall prepare a detailed written report specifying the findings of the review and all recommended changes deemed necessary to make the IIPP effective. The reviewer shall be a licensed California professional engineer, a certified safety professional, or a certified industrial hygienist.

~~SEC. 11.~~

SEC. 20. The director shall levy the assessments specified in paragraph (1) of subdivision (d) of Section 62.5 of the Labor Code to fund the total costs of the program, as prescribed by the

amendments to Section 62.5 of the Labor Code made by Section 1 of this act, retroactive to January 1, 2004.

SEC. 21. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes to the workers' compensation system at the earliest possible time, it is necessary that this act take effect immediately.

CORRECTIONS

Text — Pages 16, 17, 18, 19, and 20.

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